IRCAD · 2019

WRIST ARTHROSCOPY

ADVANCED COURSE

English-speaking course

REGISTRATION FORM

Dr./Prof. Family name _____

First name _____

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Zip code _____ City _____

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Phone _____ Mobile phone _____

E-mail _____

NOVEMBER 29-30 Limited to 17 participants

☐ **COURSE REGISTRATION WITH HOTEL IRCAD PACKAGE** _____ **2 290 €**

☐ **ADDITIONAL NIGHT:** November 30 _____ **145 €**

☐ **COURSE REGISTRATION** _____ **2 000 €**

PAYMENT

Please bill my credit card: ☐ VISA ☐ MC ☐ AMEX

N° | | | | | | | | | | | | | | | | Expiry Date | | / | | Security code | | | |

☑ I Accept the Cancellation Policies, see p.15/16

☐ Please find enclosed a check* for the total amount
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